Ontario

Ministry of Health and Long-Term Care

Ministère de la Santé et des Soins de longue durée

Inspection Report under the Long-Term Care Homes Act, 2007

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Sep 17, 2019	2019_532590_0024	016258-19, 017656-19, 017701-19	Complaint

Licensee/Titulaire de permis

Schlegel Villages Inc.
325 Max Becker Drive Suite. 201 KITCHENER ON N2E 4H5

Long-Term Care Home/Foyer de soins de longue durée

The Village of Aspen Lake
9855 McHugh Street WINDSOR ON N8P 0A6

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

ALICIA MARLATT (590)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 3, 4, 12 and 13, 2019.

During the course of the inspection, the inspector(s) spoke with the Executive Director, the Director of Nursing, four Assistant Directors of Nursing, one Neighbourhood Coordinator, two Registered Nurses, three Registered Practical Nurses, two Personal Support Workers, one resident and three family members.

During the course of the inspection, the inspector(s) reviewed one resident's clinical record, three Infoline reports and call bell records.

During the course of the inspection, the inspector(s) observed infection prevention and control practices, snack distribution, one meal service, resident and staff interactions and the posting of required information.

The following Inspection Protocols were used during this inspection:
Continence Care and Bowel Management
Medication
Personal Support Services
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
1 WN(s)
0 VPC(s)
0 CO(s)
0 DR(s)
0 WAO(s)

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Légende WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l’article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 131. Administration of drugs

Specifically failed to comply with the following:

s. 131. (1) Every licensee of a long-term care home shall ensure that no drug is used by or administered to a resident in the home unless the drug has been prescribed for the resident. O. Reg. 79/10, s. 131 (1).

Findings/Faits saillants :

1. The licensee had failed to ensure that no drug was used by or administered to a

resident in the home unless the drug had been prescribed for the resident.

A complaint was received by the Ministry of Long-Term Care from a family member of resident #001. The family member had concerns with the resident's recent hospitalizations and medication administration in the home.

Review of resident #001's clinical record showed that the resident was admitted to the hospital on a specific day and returned to the long-term care home a month later in 2019. The resident returned to the home with a prescription from the hospital's attending physician, listing many medication changes. Upon the resident's arrival to the home, the home's physician had ordered to stop all previous orders and to continue only what was ordered at the hospital.

A review of the orders written by the hospital's physician was completed, along with a review of the home's physician's orders after the hospitalization, and they were compared to the resident's current electronic Medication Administration Record (eMAR). The September 2019, eMAR showed an order for a specific therapy, which was originally ordered in January 2019. The Re-Admission Order Form dated after the hospitalization, completed by an Assistant Director of Nursing (ADON) documented that telephone orders were obtained from the physician that day. There was an order for a specific therapy, however the order was checked off as to be discontinued.

There was email correspondence in resident #001's orders. There was an email sent to the home's physician when the resident had returned from the hospital. The ADON asked about the specific therapy and other medications that were not addressed on the prescriptions provided by the hospital's physician. The physician responded to keep the medications the same as they were when the resident was in the hospital only.

Review of resident #001's care plan showed that staff were directed to administer medications as ordered.

Review of resident #001's progress notes showed that there was an entry made on the evening of the resident's return from the hospital. The entry stated that the resident was resting while utilizing the specific therapy in bed.

In an interview with ADON #111, they shared that the resident did not utilize the specific therapy while in the hospital. They shared that the order for specific therapy should have been discontinued on the eMAR and in the care plan and had not been. They shared that

all previous orders had been discontinued by the physician, and that should have included the specific therapy order. The specific therapy was removed from the resident’s orders and care plan at that time. [s. 131. (1)]

Issued on this 17th day of September, 2019

Signature of Inspector(s)/Signature de l’inspecteur ou des inspecteurs

Original report signed by the inspector.